U.S. ARMY - BAYLOR UNIVERSITY

GRADUATE PROGRAM IN HEALTH CARE ADMINISTRATION

AN ASSESSMENT OF THE ORGANIZATIONAL CULTURE

OF DEWITT ARMY COMMUNITY HOSPITAL

ONE YEAR AFTER THE IMPLEMENTATION OF TOTAL QUALITY MANAGEMENT

A GRADUATE MANAGEMENT PROJECT

SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR A

MASTERS OF HEALTH CARE ADMINISTRATION

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Dewitt Army Community Hospital (DACH), a 68 bed hospital located at Ft. Belvoir, Virginia is now one year into its quality transformation. Over the course of the past year, the hospital has invested heavily in adopting the TQM philosophy, spending over $100,000 to formally train 350 of 863 staff members in TQM. The DACH leadership desires to develop a cultural climate that reflects the TQM philosophy, i.e. a climate that fosters team work, innovation, risk taking, involvement, and concern for quality.

The purpose of this project was to assess the organizational culture of DACH as it relates to TQM. Supporting objectives were to 1) validate or refute the DACH leadership's intuitive assessment of the current culture, 2) identify areas of the culture that need additional focused attention, and 3) serve as a benchmark against which to judge future assessments in the future. The results of the study suggest that many of the practices indicative of a TQM culture are present at DACH. The staff of DACH seem to have high morale and a good awareness of their mission. They look for an dscuss ways to improve their work and are concerned about their customers.

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In recent years, many hospitals, including military
hospitals, have embraced Total Quality Management (TQM) as a
means of improving quality of services and controlling cost.
Indeed, the Joint Commission on Accreditation of Healthcare
Organizations has placed its "agenda for change" squarely
within the philosophical framework of TQM.

A difficult, yet vitally essential, aspect of adopting
the TQM philosophy is to bring about the organizational
culture change necessary to fully realize the potential of
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Supporting objectives were to 1) validate or refute the DACH

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The results of the study suggest that many of the practices indicative of a TQM culture are present at DACH. The staff of DACH seem to have high morale and a good awareness of their mission. They look for and discuss ways to improve their work and are concerned about their customers.

The study also indicates that additional attention should be focused on the areas of rewards/recognition, communication, cooperation, and developing a system/structure for quality improvement.

INTRODUCTION

Background Information

The health care industry in America today is in the
throes of massive change. New technologies, changing
demographics, and the prospect of a statutory national
health care program have caused the entire industry to re-
think how they do business. Users and purchasers of health
care services are demanding increased accountability from
the health care industry in terms of cost and quality. As
the screws of competition tighten, hospitals are looking for
ways to increase operating efficiencies, satisfy increased
demands of patients, and increase hospital market share.

Like their civilian counterparts, military medical
treatment facilities are scrambling for solid ground in the
shifting sand of health care reform. Current DoD health
care reform plans call for non-uniformed beneficiaries to be
offered an annual choice of military or civilian health care
plans; a radical change for military health care.

Historically, the military medical departments
have treated a "captive audience;" that is, military medical
beneficiaries had little choice but to use the military
medical system. To be sure, there are some individuals who
prefer military health care above all civilian options.
Beneficiaries who have other insurance policies or who were
willing to pay out of pocket can go elsewhere. But, by and

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system, if not by choice, because it is the only financially viable option.

However, if the DoD reform measures are enacted, beneficiaries will be allowed to choose between a military health plan or competing civilian health plans. Beneficiaries may likely choose their plan on the basis of their perception of the quality of care/service offered, convenience in terms of location and appointment availability, and out of pocket costs.

The DoD health care reform plan will clearly thrust the military health care system into the arena with competing civilian health plans. To ensure their competitiveness, military medical treatment facilities must adapt to the changing external environment. They must take whatever actions necessary to become the health care system of choice for DoD beneficiaries. If the military medical system is not successful in competing for eligible beneficiaries, the result may be a patient population of only active duty service members; a situation which may threaten the existence of military graduate medical education and the military health care system as it exists today.

In recent years, many hospitals, including military hospitals, have embraced Total Quality Management (TQM) as a means of improving quality of services and controlling cost. Indeed, the Joint Commission on Accreditation of Healthcare

Organizations has placed its "agenda for change" squarely within the philosophical framework of TQM.

TQM is a management philosophy built upon the principle that the key to improving quality is not to improve the actions of individuals, but to improve the process/system. Smith, Discenza, and Piland (1993) define TQM as "managing the continuous improvement of service delivery processes and outcomes through data-driven strategies and empowered staff to exceed customer expectations."

Wakefield and Wakefield (1993) believe that at its simplest, TQM espouses creating an organizational culture emphasizing employee empowerment in order to move problem identification, analysis, and resolution as far down the organizational hierarchy as possible. TQM incorporates a philosophy of innovation and change. TQM is not a quick fix. It will not make a difference if its concepts are not practiced as a way of life and incorporated into the style and culture of the organization. Many view TQM as a method of instilling quality while simultaneously achieving other desirable organizational goals such as increased productivity and decreased waste, downtime, and problem solving effort. Although leaders in the TQM field (e.g. Demming, Juran, Crosby, Ishikawa) differ on some of the fine points of TQM, there is general agreement concerning some of the basic factors required for successful implementation of TQM. Among these factors are 1) commitment of top

management, 2) a corporate vision and framework for quality,
3) quality education and training, 4) focus on continuous
improvement in quality, 5) customer focus, 6) emphasis on
improving systems/processes, 7) measurement and
experimentation, 8) recognition and communication, 9)
quality management processes, and 10) transformation of the
current organizational culture (Sahney, et al 1989).

DeWitt Army Community Hospital (DACH), a 68 bed acute
care hospital located at Ft. Belvoir, VA, is employing the
framework of TQM to respond to competitive threats and the
challenges of approaching health care reform measures. At
stake is a marketshare of over 130,000 eligible
beneficiaries of military health care.

DACH is competing with civilian health care providers
and organizations who are aggressively seeking to increase
their marketshare of DoD beneficiaries in the DACH catchment
area (a geographical area extending 40 miles around DACH).

Located in Fairfax County, VA, 12 miles south of the
District of Columbia, DACH is in a fiercely competitive and
highly sophisticated market. The geography and demographics
of the Washington D.C. Metropolitan area contribute to a
challenging mission for DACH. The geography and
demographics of the Washington D.C. Metropolitan area
contribute to a challenging mission for DACH. Dual income
families, the notorious Washington D.C. traffic patterns,
and the availability of numerous DoD and civilian medical

treatment options all contribute to form a market in which beneficiaries "shop around" for a clinic that offers convenient appointment hours, short waiting times, and quality treatment.

One treatment option available to beneficiaries are the three PRIMUS (Primary Care for Uniformed Services) clinics located in Woodbridge, Burke, and Fairfax Virginia. These primary care clinics, operated by a civilian contractor, treat all beneficiaries of military health care at no cost to the patient. Since there is no cost involved, many beneficiaries view the PRIMUS clinics as an extension of DACH. However, in an ironic sort of way, the PRIMUS clinics compete against DACH. PRIMUS is reimbursed out of DACH's direct health care budget on a "per visit" basis. Therefore, every dollar paid to PRIMUS makes one less dollar available to the DACH clinics. During FY 93, PRIMUS clinics recorded 210,557 visits by DoD beneficiaries, at a cost to DACH of over 11 million dollars, or roughly 12% of DACH's annual budget.

DACH's biggest current competitor, however, is not a single organization, but rather all civilian health care providers that accept CHAMPUS reimbursement. Many beneficiaries in Northern Virginia have third party insurance to cover CHAMPUS co-payments, so there is little financial disincentive to seek outpatient care from civilian sources. In FY 93, DACH was responsible for over 31 million

dollars in CHAMPUS reimbursement to civilian health care providers for care given to DoD beneficiaries in the DACH catchment area.

Workload data from the first six months of FY 94 indicates a decrease from previous years in outpatient visits to DACH clinics. Similarly, workload from PRIMUS clinics is down from previous years. However, CHAMPUS costs continue to rise, indicating that beneficiaries in the DACH catchment area are increasingly seeking medical care from civilian providers outside the DoD health system.

Other competitive challenges loom on the horizon as large health maintenance organizations and independent practice associations position themselves to be one of the health plan choices offered to DoD beneficiaries under proposed reform plans.

The DACH leadership believes that the foundation to health care delivery is primary care. Whoever controls the primary care base will drive the rest of the health care system.

Guided by the TQM philosophy, DACH is seeking to establish a comprehensive primary care health system in northern Virginia. DACH's plan centers around the development of primary care provider groups. The primary care provider groups are composed of two family practice physicians, a pediatrician, an internist, a nurse practitioner, a physician's assistant, and ancillary/support

staff. Primary care provider groups will be located in DACH as well as satellite clinics throughout northern Virginia.

Current plans call for a modification to the PRIMUS contract, allowing active duty primary care practice groups to replace the contracted professional staff in the three PRIMUS clinics. The PRIMUS clinics would then be operated as a joint venture between DACH and the civilian contractor. The PRIMUS contractor will be compensated on a negotiated flat rate basis, rather than a "per visit" basis. The "new" PRIMUS clinics will offer beneficiaries a broader scope of services than currently offered at PRIMUS, to include optometry, nutritional and wellness programs, and a comprehensive well woman service.

Ultimately, all of DACH's TQM efforts are to improve access to care, improve the quality of care, and decrease the cost of delivering care. In doing so, the DACH leadership believes that they can make the DACH health care system the system of choice for DoD beneficiaries.

Statement of the Management Problem

Upon taking command of DACH in January 1993, Colonel Warren Todd was charged by the Army Surgeon General to develop a health care system for Northern Virginia grounded in the tenets of total quality management (TQM) which would improve access to care and improve the quality of care.

Colonel Todd accepted this challenge and embarked upon the mission of instilling TQM at DACH.

A difficult, yet vitally essential, aspect of adopting the TQM philosophy is to bring about the organizational culture change necessary to fully realize the potential of TQM. Entrenched personal philosophies and long held cultural attitudes do not die easily. It is especially difficult to change the organizational culture in a highly bureaucratic, vertically structured, military hospital such as DACH.

DACH is now one year into its quality transformation. Over the course of the past year, the hospital has invested heavily in adopting the TQM philosophy, spending over $100,000 to formally train 350 of DACH's 863 staff members in TQM. Numerous process action teams have begun to investigate ways to improve services at DACH.

DACH's plan for a comprehensive, community based primary care system could well decide the future of military health care in the National Capital Region. For this plan to succeed, it is essential that DACH have a cultural climate that reflects the TQM philosophy, i.e. a climate that fosters team work, innovation, risk taking, involvement, and concern for quality.

The management problem that the DACH leadership faces is that no one has yet assessed the DACH organizational climate as it relates to the implementation of TQM. DACH

has committed much time, money and effort into developing a TQM culture, but no one knows, beyond a notional sense, if it is accomplishing its intended purpose. The DACH leadership has no empirical basis upon which it can measure progress made to date, assess the current organizational culture, or chart future directions.

Literature Review

TQM is an extremely popular concept in business and management today. The application of TQM to the health care field has become increasingly prevalent in recent years and is well documented in the literature. A common thread found throughout the literature concerns the idea of TQM as a total paradigm shift in health care management. The management requirements of TQM are not aligned with the traditional management style, culture, and organizational structure of the typical medical organization (Bender, Geoghegan, and Krasnick 1990). There are some unique challenges in applying TQM to a health care setting as opposed to an industrial setting. Recognizing these challenges and developing strategies to address these challenges are essential for making progress toward developing effective and efficient health care organizations.

Batalden (1989) outlined several points that health care leadership must learn to implement TQM successfully:

1) management must learn the meaning of quality, understand the importance of the customer, and realize that there are multiple customers in the production process; 2) top management must encourage the continuous improvement of quality, including the wise use of teams that can work together to improve systems; and 3) management must learn the meaning of statistical thinking: how to speak with data and manage with facts, how to take the guess work out of decision making, how to reduce variation and unnecessary complexity through the use of standard data analysis and display tools, and how to link the results of the use of these tools with appropriate management actions (Batalden 1989).

Resistance to change is a common phenomena, particularly in long established bureaucratic organizations. Several reasons for the resistance to TQM in the health care field are noted in the literature. McLaughlin and Kaluzny (1990) note that initiating a TQM program in a health care environment can be difficult because of the conflict between the relentless inquiry of TQM and the established norms of professional autonomy. TQM is a fundamental challenge to the way all professionals think about quality, evaluate and regulate themselves, and gain and protect their professional domains and autonomy.

Demming (1986) estimates that 85% of the errors in a given process are the result of problems with the system

rather than the type of random errors and mistakes made by people. This runs counter to the prevailing assumption in health care that a problem is the result of someone's individual mistake rather than of the larger structure or system in which the individual functions (McLaughlin and Kaluzny 1990).

Concerning professional autonomy and responsibility, Berwick, Godfrey, and Roessner (1990) write that a central tenet of quality improvement theory, that quality is made not by people but by process, flies in the face of a central myth of health care - that quality is made by doctors. Traditionally, doctors were trained to believe that they alone were completely responsible for the care they gave, and that their patients wanted it so. The idea of health care as a "production process" by any name was a violation of the self-image of the profession and the desire of the patients. Johnson and Boss (1991) agree that the health professional's expectations of independence and autonomy create a barrier to change in health care organizations.

Wakefield and Wakefield (1993) write that health care workers often display a greater allegiance to a profession's body of knowledge and behavior codes than to the values and goals of their employer. This has led to the development of long-standing interprofessional turf battles over areas of patient care responsibility, authority, and resource control. The mind set of "us versus them" may limit the use

of TQM initiatives, even when there is a common focus of improving patient care.

Wakefield and Wakefield (1993) suggest several strategies for managing resistance from the medical staff. Among the strategies are to: 1) involve physicians in activities that are of direct clinical relevance to patients, 2) build on strengths, not weaknesses of the medical staff by initially targeting those most receptive to the TQM idea, 3) present "hard" data to physicians about existing practice, not "opinions" of nonphysicians and nonscientists, 4) invest in educating physicians in management skills. To some extent, the TQM implementation process can become the basis for an internal management development program.

Bice (1990a) supports the idea of training physicians as a key component of successfully implementing TQM. Bice quotes George Labowitz in saying that training is "the focal instrument for change." Labowitz adds that to maximize its effectiveness, training must be aligned with the vision of the future that the organization seeks to implement.

Management training for physicians is an essential element in reshaping a corporate culture, according to Joel Shalowitz, director of the Northwestern University program in hospital and health services management (Bice 1990a). Shalowitz believes that physicians primarily need education in basic finance, encompassing an understanding of the

hospital's financial statements, ratio analysis, and the use of tools to measure return on investment (Bice 1990a).

An important element of TQM is to focus on the needs of the customer. However, defining the customer in a health care environment may be difficult. Certainly, health care patients are customers, just as the many users of any given department's output are also customers. The criterion is not whether or not the work meets professional standards, but whether the user, often a member of a different profession, is satisfied with its timeliness and utility (McLaughlin and Kaluzny 1990).

Perhaps the most critical single factor in ensuring the success of TQM is the senior leader. The most important thing the senior leader does is create a vision for the organization. The leader's vision serves as a beacon, a rallying point for the organization (Goodwin 1992). The leader must communicate the vision in terms that involve shared values, align the staff to that vision, and build an effective team based on healthy personal relationships (Manthey 1992).

The vision statement should be a clear and relatively simple statement of how the organization will look in the future, focusing on both internal and external aspects. Externally, a vision describes what the customer will receive or experience when he or she contacts the organization. Internally, the vision depicts how the

organization will operate to deliver what the customer wants (Stump 1994).

Melum (1990) notes that vision statements are most effective when they are, 1) converted into specific and actionable performance standards, 2) based on input from throughout the organization and therefore broadly "owned" by employees, and 3) communicated clearly, consistently, and continually throughout the organization.

McConnell (1992) agrees that the most critical ingredient essential to the successful implementation of TQM is top management commitment. McConnell notes that TQM will not work as intended unless top management is actually involved and actively promoting the concept. McConnell warns readers to beware of the skyrocket commitment of the top manager who gets all fired up over TQM, distributes information to everyone, creates a TQM steering committee, and chairs the first few meetings, and then starts missing meetings because "pressing business" defaults the guiding role to subordinates.

Kaluzny (1989) characterizes the leader as a symphony conductor, orchestrating the independent actions of a variety of professionals and project-oriented teams. The role of top management is to manage the culture and to allocate resources to support the change process.

Bedwell (1993), in writing about TQM and nonprofit organizations, notes that the most difficult part of a total

quality commitment is to change the organizational culture
from one that dwells on status quo to one that gets excited
about change. The TQM culture demands continued, small
innovations and improvements from everyone in the
organization. Top leadership must promote it, managers and
employees must practice it, everyday.

Change doesn't come easy to organizations. Martin
(1993) notes that organizations defend against change not
because they are individuals, but because they are made up
of individuals who are working at what always has worked.
It is when responding to markets transformed by intense and
unpredictable change that businesses are most confounded by
patterns of past success. Organizations fail to make the
most of new opportunities because they are still doing their
best to make the most of old opportunities. In other words,
the very practices that made businesses successful in the
past may, if unchanged, doom them to failure in the future.

Moskal (1992) remarks that the greatest nemesis that
organizations face is change. During a period of
organizational change, individuals/teams will exhibit a
great deal of uncertainty, engage in self-preservation, and
have an unquenchable need for information. Organizations in
change may experience communication problems, power
struggles, and a decrease in productivity. It is the
responsibility of leaders to help the organization view the
change as an opportunity and not a threat.

However, many American business leaders are not comfortable with managing change. A Gallup poll of 400 executives from Fortune 1000 companies yielded the following results:

- 62 percent believe they have a conservative or reluctant approach to change.

- More than 75 percent say that American managers resist change because they are "too short-term oriented," they "don't like to lose control of people or events," they have "a vested interest in the status quo," and they "do not know what to do about change."

- Only 47 percent rate their organizations as "very capable" of change.

In spite of the apparent inability to effectively manage change, 79 percent of the executives interviewed characterized the pace of change at their companies as "rapid" or "extremely rapid" and 61 percent believe the pace will pick up in the future (Ettorre 1994).

Interestingly, Ettorre (1994) notes that the majority of the executives sampled spent their careers in risk-reward corporate systems that promoted people who did not take risks and, therefore did not make mistakes. Perhaps the same could be said about the "play it safe", "risk aversion" mentality of the military promotion system.

Several authors acknowledge that the best way to approach change is proactively. Organizations with a

strategic plan and clear vision for managing change will most likely be successful. (Broome 1990, Aird 1990, Gambrell and Stevens 1992, Liberatore 1993).

In discussing organizational change, Gambrell and Stevens (1992) note that, despite the necessity for change, employees have a strong need to have their previous work acknowledged. Management should clearly communicate the reasons for the change and the transferability of the employee's previous skills, methods, or task management styles to the new organizational context. If workers see acknowledgment and team acceptance for their efforts, the change will be easier to accept.

Employee participation in the change process is a central tenet of TQM. Scotti et al (1993) assert that no quality program can succeed in the long run if it is unable to address the working needs of the employees who operate it. In describing the Patient Care Improvement Program at Mount Sinai Medical Center, New York, Eichhorn, Speedling, and Rosenberg (1991) note that people can and will seek change that reflects their ideals and permits them to share in shaping the future. Six principles guided the dynamics of Mount Sinai's program: 1) include everyone, 2) treat patients as partners, 3) maintain a balance between forces for change and continuity, 4) ensure that innovation and change are data driven, 5) get it from the source, and 6) support internal diversity.

In determining the need to conduct an organizational assessment, Furnas (1990) indicates that organizations that have adopted the TQM program need to assess their progress toward quality improvement. Among the tools available to assess organizations are employee surveys, interviews, record audits, observation by third parties, and group meetings. Management should select the best tool for their intended purpose.

Surveys do not provide a direct measure of quality, but instead, provide an assessment of the employees perception of quality. With this in mind, surveys can be an effective tool to identify the perception and climate of the organization (Furnas 1990).

Surveys using the Likert scale are very popular in research and require subjects to indicate their degree of agreement or disagreement with each of a series of statements. Most published research using a Likert scale used a scale with an odd number of responses, with five possible responses being the most popular (Checkoway and Zimmerman 1992). In his book New Ways of Managing Conflict (1976), Rensis Likert, the developer of the Likert scale, used a survey with a Likert scale to measure attitudes of employees, thus adding credibility to the use of surveys to measure attitudes.

Purpose of the Project

The purpose of this project is to assess the organizational climate of DACH one year after the implementation of TQM. The project will provide an assessment of the current organizational climate as it relates to the DACH TQM effort. Supporting objectives of the project are to 1) validate or refute the DACH leadership's intuitive assessment of the current organizational climate, 2) identify areas of the culture that need additional focused attention, and 3) serve as a benchmark against which to judge similar assessments in the future.

Although no formal hypotheses are suggested, the functional relationships to be examined are as follows: The DACH's organizational climate/culture is a function of the following organizational variables (survey questions that relate to each variable are noted to the right).

	Variable	Questions
a.	Awareness of strategic challenge	1, 2, 3
b.	Vision of the future	4, 5, 6
c.	Innovation	7, 8
d.	Quality policy/philosophy	9, 10, 11
e.	Value systems/ethics	12, 13, 14
f.	Leader's involvement	15, 16, 17
g.	Leader's visible commitment to goals	18, 19, 20
h.	Supervisor's role in quality improvement	21, 22, 23

Variable	Questions
i. Supervisor's concern for improvement	24, 25, 26
j. System/structure for quality improvement	27, 28
k. Awareness of productivity/quality issues	29, 30
l. Attitudes/Morale	31, 32, 33
m. Cooperation	34, 35, 36
n. Involvement	37, 38
o. Perceptions of the work environment	39, 40, 41
p. Social interactions	42, 43
q. Task characteristics	44, 45, 46
r. Rewards/recognition	47, 48, 49, 50, 51
s. Customer orientation	52, 53, 54, 55
t. Communications	56, 57, 58

METHODS AND PROCEDURES

Data for the assessment of the organizational climate were gathered using a modified version of the Quality and Productivity Self-Assessment Guide for Defense Organizations - Version 2.0 (Work Force Module). General Research Corporation developed the survey instrument through a contract with the Defense Productivity Program Office, Office of the Assistant Secretary of Defense (Force Management and Personnel). The Work Force Module of the Quality and Productivity Self-Assessment Guide for Defense Organizations focuses on assessing the organizational climate.

The survey instrument was modified by changing the rating scale from a six point to a five point Likert scale. A five point scale allows respondents a neutral point for items to which they neither agree nor disagree.

The reliability and validity of the original survey instrument have been demonstrated through testing at many DoD organizations, to include numerous DoD hospitals such as the Naval Medical Center, San Diego, CA.

Reliability refers to the consistency of measure. An instrument is reliable to the degree that it supplies consistent results. The reliability of the survey instrument is enhanced by the fact that each of the twenty organizational variables (e.g. awareness of strategic challenge, vision for the future, etc.) are measured by several different survey statements. Also, only one researcher was involved in administering the survey, thus reducing variability in the way the survey was administered.

Validity refers to the degree that the survey instrument measures what it is intended to measure. A pilot study was conducted from 7 - 11 March 1994, to establish the validity of the modified survey instrument for measuring the organizational culture at DACH. The pilot study was conducted to determine the applicability of the survey to a health care organization, identify any problems with the wording of the survey, and determine if the scope of the survey was adequate to accomplish its purpose.

Five members of the senior leadership of DACH and five staff members (three civilian and two military) participated in the pilot study. The senior leaders that participated in the pilot study were the Commander; Deputy Commander for Clinical Services; Deputy Commander for Administration; Chief, Department of Nursing; and the Command Sergeant Major. The five other staff members that participated in the pilot study were randomly selected from a list of names. The results of the pilot study indicated that the survey was a valid and appropriate instrument for measuring the organizational culture in a health care organization.

The survey was given to a random sample of 50% of the assigned military and 50% of the assigned civilian workforce. Specific members of the senior leadership were surveyed so that their perceptions of the organizational climate could be compared to the rest of the organization. The total survey distribution was as follows:

Senior Leadership   5 people surveyed

Military Staff   50% of 413 = 207 people surveyed

Civilian Staff   50% of 450 = 225 people surveyed

                   Total = 437 people surveyed

A systematic sampling methodology was used to identify the 50% sample population. Every other name was selected on alphabetical rosters of military and civilian staff members. To ensure that every name on the roster had an equal chance of selection, a coin toss determined the

starting point between the first two names. After identifying individuals to be included in the sample population, the survey instrument and directions for completing the survey were distributed.

The survey instrument consists of 58 positively phrased statements. Respondents were asked to indicate their opinion of the statement on a scale of 1 to 5 with 1 indicating that they strongly disagree with the statement and 5 indicating that they strongly agree. Respondents who neither agree nor disagree with the statement could select the neutral position (number 3) on the scale.

Statements on the survey instrument are grouped so that, taken together, they give an assessment of a particular variable of the organizational climate, i.e. awareness of strategic challenge, vision for the future, innovation, etc. All of the variables examined in the study are listed in the "Purpose" section of this paper.

To insure respondent confidentiality, no names or other means of personal identification appeared on the survey form. To further insure individual confidentiality, respondents were instructed that they could put their completed surveys in one of several boxes at designated locations in the hospital. Respondents were asked to indicate on the survey whether they were a military or civilian staff member.

RESULTS

A total of 228 surveys were returned from the combined military and civilian staff, corresponding to a response rate of 53 percent. The response rate was approximately equal for military (50 percent) and civilian (55 percent) staff members. Additionally, 5 surveys (100 percent) were returned from the senior leadership. Descriptive statistics based on the combined staff's response to the 58 survey statements are reported in table 1.

Survey items were grouped to assess the twenty organizational variables. These twenty variables are various component parts of the organizational culture. Mean scores and standard deviation for each of the variables as scored by the combined military and civilian staff are listed in Table 2. The mean scores and standard deviation for each of the variables as scored by the senior leadership, military staff, and civilian staff are listed in Tables 3, 4, and 5 respectively. A score greater than 3.0 indicates the presence of a practice typically considered to contribute to a quality organizational culture.

DISCUSSION AND RECOMMENDATIONS

My analysis will focus primarily on the data from the combined staff response. The combined staff represents the rank and file of the hospital and is the best representation of the total population.

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Table 1 - Descriptive Statistics of Combined Staff Response (N = 228)

	Survey Statement # 1	Survey Statement # 2	Survey Statement # 3	Survey Statement # 4	Survey Statement # 5	Survey Statement # 6	Survey Statement # 7	Survey Statement # 8	Survey Statement # 9	Survey Statement # 10	Survey Statement # 11	Survey Statement # 12	Survey Statement # 13	Survey Statement # 14	Survey Statement # 15
Mean Score	3.710526	4.052632	3.824561	3.289474	3.289474	3.035088	3.491228	3.263158	3.140351	3.447368	3.210526	3.263158	3.368421	2.859649	3.114035
Standard Error	0.072347	0.063906	0.083515	0.077504	0.070178	0.071922	0.069359	0.071988	0.076578	0.068149	0.078864	0.071449	0.071563	0.078571	0.081412
Median	4	4	4	4	3	3	4	4	3	4	3	3	4	3	3
Mode	4	5	5	4	4	2	4	4	4	4	4	4	4	3	3
Standard Deviation	1.092414	0.964955	1.261044	1.170291	1.059662	1.085993	1.047301	1.086989	1.156306	1.029025	1.190814	1.078853	1.080571	1.186393	1.229296
Variance	1.193369	0.931138	1.590231	1.36958	1.122284	1.17938	1.096839	1.181544	1.337043	1.058892	1.418038	1.163923	1.167633	1.407528	1.511168
Range	4	3	4	4	4	4	4	4	4	4	4	4	4	4	4

	Survey Statement # 16	Survey Statement # 17	Survey Statement # 18	Survey Statement # 19	Survey Statement # 20	Survey Statement # 21	Survey Statement # 22	Survey Statement # 23	Survey Statement # 24	Survey Statement # 25	Survey Statement # 26	Survey Statement # 27	Survey Statement # 28	Survey Statement # 29	Survey Statement # 30
Mean Score	3.622807	3.324561	3.052632	3.622807	2.903509	3.578947	3.280702	3.140351	3	3.114035	2.754386	2.964912	3.210526	2.824561	3.464912
Standard Error	0.07109	0.067237	0.079044	0.061783	0.082455	0.076587	0.078389	0.082411	0.080092	0.078513	0.080362	0.07456	0.063683	0.073682	0.065304
Median	4	3	3	4	3	4	3	3	3	3	3	3	3	3	4
Mode	4	3	4	4	4	4	4	4	4	3	2	4	4	3	4
Standard Deviation	1.07343	1.015263	1.193537	0.932907	1.245038	1.156439	1.183654	1.244386	1.209361	1.185513	1.213445	1.125827	0.961585	1.112568	0.986069
Variance	1.152253	1.03076	1.42453	0.870315	1.55012	1.337352	1.401036	1.548497	1.462555	1.405441	1.472448	1.267486	0.924646	1.237808	0.972332
Range	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4

	Survey Statement # 31	Survey Statement # 32	Survey Statement # 33	Survey Statement # 34	Survey Statement # 35	Survey Statement # 36	Survey Statement # 37	Survey Statement # 38	Survey Statement # 39	Survey Statement # 40	Survey Statement # 41	Survey Statement # 42	Survey Statement # 43	Survey Statement # 44	Survey Statement # 45
Mean Score	3.833333	3.280702	3.614035	2.877193	2.815789	3.175439	3.578947	3.649123	2.394737	3.140351	4.04386	3.605263	3.421053	2.877193	2.938596
Standard Error	0.062112	0.078881	0.065498	0.069301	0.075403	0.057812	0.060841	0.061528	0.079908	0.075049	0.056559	0.070669	0.074021	0.074669	0.079746
Median	4	3	4	3	3	4	3	4	2	3.5	4	4	4	3	3
Mode	4	4	4	3	2	3	4	4	2	4	4	4	4	2	4
Standard Deviation	0.937864	1.191074	0.989004	1.046415	1.138558	0.872947	0.918673	0.929046	1.206578	1.133216	0.854017	1.067076	1.117697	1.127473	1.204142
Variance	0.879589	1.418657	0.978128	1.094984	1.296313	0.762037	0.84396	0.863127	1.455831	1.28418	0.729345	1.138651	1.249246	1.271196	1.449957
Range	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4

	Survey Statement # 46	Survey Statement # 47	Survey Statement # 48	Survey Statement # 49	Survey Statement # 50	Survey Statement # 51	Survey Statement # 52	Survey Statement # 53	Survey Statement # 54	Survey Statement # 55	Survey Statement # 56	Survey Statement # 57	Survey Statement # 58
Mean Score	3.096491	2.657895	2.95614	2.973684	2.798246	2.561404	3.736842	3.649123	3.175439	3.140351	2.745614	2.842105	3.070175
Standard Error	0.076119	0.076554	0.085411	0.084075	0.085316	0.071978	0.065229	0.064592	0.068236	0.066881	0.071318	0.082272	0.077002
Median	3	3	3	3	3	2	4	4	3	3	3	3	3
Mode	4	4	4	3	2	2	4	4	3	4	2	3	4
Standard Deviation	1.149367	1.155938	1.289677	1.269504	1.288238	1.086846	0.984932	0.975312	1.030338	1.009882	1.076881	1.242273	1.162705
Variance	1.321045	1.336193	1.663266	1.611639	1.659556	1.181235	0.97009	0.951233	1.061597	1.019862	1.159672	1.543241	1.351882
Range	4	4	4	4	4	4	4	4	4	4	4	4	4

Table 2 - Mean Scores for Organizational Variables
Combined Staff Response

Organizational Variable	Mean	Std Dev	95% Confidence Interval	
Awareness of Strategic Challenge	3.92	0.73	3.82	4.01
Vision for the Future	3.10	0.96	2.97	3.22
Innovation	3.22	1.02	3.09	3.36
Quality Policy/Philosophy	3.32	0.88	3.20	3.43
Value Systems/Ethics	3.35	0.88	3.23	3.46
Leader's Involvement	3.29	1.00	3.16	3.42
Leader's Visible Commitment to Goals	3.42	0.89	3.30	3.53
Supervisor's Role in Quality Improvement	3.18	1.06	3.04	3.32
Supervisor's Concern for Improvement	3.13	1.01	3.00	3.26
System/Structure for Quality Improvement	2.82	0.92	2.70	2.94
Awareness of Productivity/Quality Issues	3.14	0.91	3.02	3.26
Attitudes/Morale	3.58	0.88	3.46	3.69
Cooperation	2.96	0.85	2.85	3.07
Involvement	3.61	0.81	3.51	3.72
Perceptions of Work Environment	3.19	0.78	3.09	3.29
Social Interactions	3.51	1.03	3.38	3.65
Task Characteristics	2.97	0.85	2.86	3.08
Rewards/Recognition	2.79	0.93	2.67	2.91
Customer Orientation	3.43	0.75	3.33	3.52
Communications	2.89	0.98	2.76	3.01

Number of Questionnaires: 228

Table 3 - Mean Scores for Organizational Variables
Senior Leadership Response

Organizational Variable	Mean	Std Dev	95% Confidence Interval	
Awareness of Strategic Challenge	4.20	0.38	3.73	4.67
Vision for the Future	3.00	0.67	2.17	3.83
Innovation	4.20	1.04	2.91	5.49
Quality Policy/Philosophy	3.47	0.87	2.39	4.55
Value Systems/Ethics	3.93	0.49	3.32	4.55
Leader's Involvement	4.07	1.04	2.78	5.36
Leader's Visible Commitment to Goals	3.80	0.45	3.24	4.36
Supervisor's Role in Quality Improvement	3.67	1.13	2.26	5.07
Supervisor's Concern for Improvement	3.27	1.19	1.79	4.74
System/Structure for Quality Improvement	2.70	0.57	1.99	3.41
Awareness of Productivity/Quality Issues	2.90	0.65	2.09	3.71
Attitudes/Morale	3.60	0.80	2.61	4.59
Cooperation	2.73	0.80	1.75	3.72
Involvement	3.40	0.55	2.72	4.08
Perceptions of Work Environment	3.47	0.90	2.35	4.58
Social Interactions	3.20	0.91	2.07	4.33
Task Characteristics	2.80	0.30	2.43	3.17
Rewards/Recognition	3.08	0.81	2.08	4.08
Customer Orientation	3.25	0.81	2.24	4.26
Communications	3.07	0.72	2.17	3.96

Number of Questionnaires: 5

Table 4 - Mean Scores for Organizational Variables
Military Staff Response

Organizational Variable	Mean	Std Dev	95% Confidence Interval	
Awareness of Strategic Challenge	3.75	0.81	3.59	3.91
Vision for the Future	2.94	1.00	2.75	3.14
Innovation	3.21	1.03	3.01	3.41
Quality Policy/Philosophy	3.22	0.85	3.05	3.38
Value Systems/Ethics	3 24	0.92	3.06	3.42
Leader's Involvement	3.14	0.99	2.95	3.33
Leader's Visible Commitment to Goals	3.24	0.90	3.07	3.42
Supervisor's Role in Quality Improvement	3.11	1.00	2.91	3.30
Supervisor's Concern for Improvement	3.04	0.95	2.86	3.23
System/Structure for Quality Improvement	2.65	0.98	2.46	2.84
Awareness of Productivity/Quality Issues	2.97	0.91	2.80	3.15
Attitudes/Morale	3.44	0.85	3.27	3.60
Cooperation	2.87	0.90	2.69	3.04
Involvement	3.55	0.83	3.39	3.71
Perceptions of Work Environment	3.09	0.72	2.95	3.23
Social Interactions	3.46	1.00	3.27	3.66
Task Characteristics	2.87	0.76	2.73	3.02
Rewards/Recognition	2.73	0.86	2.57	2.90
Customer Orientation	3.24	0.70	3.10	3.38
Communications	2.75	0.94	2.57	2.93

Number of Questionnaires: 104

Table 5 - Mean Scores for Organizational Variables
Civilian Staff Response

Organizational Variable	Mean	Std Dev	95% Confidence Interval	
Awareness of Strategic Challenge	4.05	0.63	3.94	4.17
Vision for the Future	3.23	0.91	3.07	3.39
Innovation	3.23	1.01	3.06	3.41
Quality Policy/Philosophy	3.40	0.91	3.24	3.56
Value Systems/Ethics	3.44	0.83	3.29	3.59
Leader's Involvement	3.41	0.99	3.24	3.59
Leader's Visible Commitment to Goals	3.56	0.85	3.42	3.71
Supervisor's Role in Quality Improvement	3.24	1.11	3.05	3.44
Supervisor's Concern for Improvement	3.20	1.06	3.01	3.39
System/Structure for Quality Improvement	2.96	0.84	2.81	3.11
Awareness of Productivity/Quality Issues	3.28	0.89	3.13	3.44
Attitudes/Morale	3.69	0.90	3.54	3.85
Cooperation	3.03	0.79	2.89	3.17
Involvement	3.67	0.80	3.53	3.81
Perceptions of Work Environment	3.28	0.81	3.14	3.42
Social Interactions	3.56	1.05	3.37	3.74
Task Characteristics	3.05	0.92	2.89	3.22
Rewards/Recognition	2.84	0.98	2.66	3.01
Customer Orientation	3.58	0.76	3.45	3.72
Communications	3.00	1.01	2.82	3.18

Number of Questionnaires: 124

The data suggests that DACH possesses many of the positive variables associated with a quality culture. The combined military and civilian staff scored fifteen of the twenty organizational variables greater than the target score of 3.0.

Cultural Strengths

The areas of greatest strength at DACH, according to the combined staff scores, are 1) Awareness of Strategic Challenge, 2) Involvement, 3) Attitudes/Morale, 4) Social Interactions, and 5) Customer Orientation.

Awareness of strategic challenge was the highest scored variable from all survey groups. The high score suggests that both the leadership and staff are well aware of the competitive challenges and changing economic conditions that DACH faces in the future.

The second highest scored variable from the combined staff was in the area of employee involvement. This score indicates that staff members generally feel like their ideas and opinions are given careful consideration and that they are allowed to be part of the work unit or organizational team.

Attitudes/morale and social interaction were the third and fourth highest scored variables according to the combined staff. It is not surprising to find these two variables closely linked, either high or low, since they would seem to compliment one another. At first glance, social interactions may not seem to be related to quality or productivity improvement. However, in most

successful organizations, people are required to work together
toward a common goal. It is certainly easier and more enjoyable
to work together in a friendly social atmosphere and, most
likely, more productive as well.

The fifth highest scored variable according to the combined
staff was customer orientation. This score indicates that DACH
staff members believe that they are customer oriented. A high
score in this area is a very positive quality indicator for DACH.
The impetus for quality improvement begins with the customer.
The bottom line for the customer is whether he or she obtains the
services desired. It would be interesting to see how customers
rate the staff in terms of customer orientation. Data from the
DACH Patient Representative indicate that patient (external
customers) compliments have outnumbered complaints 2 to 1 for the
past several months.

Cultural Weaknesses

The combined staff scored five areas below the target score
of 3.0. These areas were, 1) Rewards/Recognition, 2)
System/Structure for Quality Improvement, 3) Communications, 4)
Cooperation, and 5) Task Characteristics. The senior leadership
agreed with the staff in scoring three of the same areas below
3.0 (system/structure for quality improvement, cooperation, and
task characteristics). However, the senior leadership differed
from the staff in their scores concerning rewards/recognition,
and communications. The senior leadership scored

rewards/recognition and communications in the positive range (higher than 3.0), while the combined staff scored both areas in the negative range (below 3.0). This indicates that perhaps the current rewards/recognition practices and communications are not as effective as the senior leadership may believe.

Rewards/recognition was the lowest scored variable by the combined staff, with a mean score of 2.79. The military staff scored the item lower than the civilian staff (2.73 vs. 2.84). These scores are in contrast with the senior staff, who scored rewards/recognition at 3.08. Survey statement number 51, "The organization rewards the people in the work unit for working together", was the second lowest scored individual statement in the survey (mean score of 2.56). The Army tradition of rewarding individual effort tends to motivate people to act in their own best interest rather than the interest of the whole. When staff, who are interdependent on one another for service delivery, compete against one another, quality suffers. The low scores given to this statement correspond with the low scores given to the "cooperation" variable, discussed later.

The formal awards system, for both military and civilian staff, is governed by numerous governmental rules and regulations, as well as union agreements. Supervisors in the federal sector are fairly limited in the scope of rewards they can bestow. However, there are many ways to

recognize and reward good performance. Top performing individuals and teams can be recognized by a special note of thanks from the commander, a picture in the newspaper, special parking place (especially valued during the winter months), certificates, mementos, or special pins to be worn on the identification badge. Another idea is to reinvest in the employee by awarding a recent best selling book on how to improve personal/job performance or to pay for the employee to attend a professional development program.

The senior leadership and staff agree that systemic/structural barriers exists that inhibit quality improvement at DACH. DoD hospitals have traditionally organized as stovepipe organizations with minimal interaction of the various departments and services. This type structure is not conducive to integrative, cross functional work that is characteristic of the total quality management philosophy. Team building among and between physicians and staff of various departments can have significant benefits in terms of quality, productivity, and patient care.

The combined staff also identified communications as a weak area in the organization, with a mean score of 2.89. On the other hand, the senior staff mean score for communication, 3.07, reflects a slightly positive opinion about communication in the organization. The score of the combined staff indicates that they may not be getting the

information they need to do their jobs effectively. As Moskal (1992) noted, during times of change and uncertainly, people have an unquenchable need for information.

Certainly, the past year at DACH has been one characterized by change; either change that has already happened, or change that is on the near horizon. Perhaps the atmosphere of change and uncertainty at DACH has exacerbated the staff's need for information. This makes it particularly important for supervisors at all levels to pass information to their subordinates. Too often information passed at the department/service chief's meeting never leaves the conference room. The recent initiation of a electronic newsletter is a good way to get timely information directly to the front line worker level.

Cooperation was another variable scored low by the combined staff (2.96). The scores in this category suggest that a spirit of cooperation and teamwork may not exist in all areas of the organization. One possible reason could be that people are not rewarded for working together to accomplish a team effort. When individuals are rewarded only for their own accomplishments, teamwork may suffer.

However, strong team identity can also have some dysfunctional effects. When staff view themselves as a distinct department, a professional group, or a separate team, there is a tendency for the greater organization's interest to be suboptimized. Attention may be focused away

from customers and toward self/team interest. Senior
leaders must insure that team efforts that focus on
customers are rewarded. The recent initiation of a "Team of
the Quarter" award at DACH is a step in the right direction.

The fifth variable scored low (2.97) by the combined
staff was task characteristics. Sometimes barriers to
quality improvement can be found in the tasks themselves.
People need the appropriate supplies, equipment,
information, and/or time to accomplish their work. This
score indicates that one or more of these barriers may
exist. This score also indicates that the staff does not
believe that the distribution of work among the people in
their work unit is well balance. Few things are more
frustrating than trying to do a job without the right tools
directions, or authority. Supervisors may get so involved
in planning for the future that they forget to provide for
the here and now. The DACH leadership expects a lot from
the staff, in terms of performance. It is incumbent upon
the leadership to insure the staff has the resources and
authority to fully meet that expectation.

CONCLUSION

The results of this study suggest that many of the practices indicative of a TQM culture are present at DACH. The heavy investment in developing the TQM philosophy at DACH appears to be paying off, at least in terms of the organizational culture.

The staff of DACH seem to have high morale and a good awareness of their mission. They look for and discuss ways to improve their work and are concerned about their customers. All of these qualities are foundational to creating an organization built upon the tenets of TQM.

The study indicates that, in order to further enhance the organizational climate, the DACH leadership needs to focus future attention on recognizing and rewarding both individuals and groups for their performance. Even highly motivated employees will become discouraged if they feel their efforts are unnoticed or unappreciated. Also, leaders need to ensure that staff members have the necessary tools and materials to get the job done.

Another area upon which the DACH leadership needs to focus attention is communication; both vertically and horizontally. With all the rapid changes occurring in the organization, it's imperative that the leadership make every effort to keep the staff abreast of where the organization is in terms of organizational structure and mission.

The process of adopting and institutionalizing TQM and the resulting culture change, like all organizational change processes, takes time even under the best of circumstances. Many experts suggest three to five years as a realistic time frame for making such a sweeping change. This study indicates that, after one year, the resources committed to developing a TQM culture at DACH have accomplished much of their intended purpose. Furthermore, the leadership of DACH now has a benchmark against which future organizational culture assessments can be measured.

APPENDIX

INSTRUCTIONS FOR COMPLETING THE ORGANIZATIONAL CULTURE
QUESTIONNAIRE.

1. The survey consists of 58 statements, to which you are to
indicate whether (and how much) you agree or disagree with the
statement. Select the letter that best describes your degree of
agreement or disagreement with the statement.

2. Mark all your answers on the green answer sheet using a no. 2
lead pencil. Completely darken the block of your desired answer.
Do not put your name or any other marks on the answer form.

3. Some of the questions ask you to consider the "organization"
in your answer. For these statements, consider the organization
to be DeWitt Army Community Hospital. Other statements ask you
to consider your "work unit" in your answer. Consider your work
unit to be your immediate work area or service.

4. Additional terms which you will find are defined below:

        Leader(s) = People at the highest levels of the
organization, i.e. Commander, Deputy Commander for
Administration, Deputy Commander for Clinical Services, Command
Sergeant Major, and all Department Chiefs.

        Customer(s) = Anyone who receives the work that the work
unit, or the organization performs. All our patients are
considered our customers (external customers), but also other
work units or organizational members (internal customers) that
use your product or service. In all cases consider that
customers rely on and judge the quality of the work they receive.

5.   No names, numbers, or any other means to identify
individuals are used in this survey. All responses are
anonymous.

6. **Please complete and return the survey answer sheet no later
than 23 March 94**. You may return your completed answer sheet to
any of the boxes marked "Organizational Culture Survey" at the
following locations: 1) Information desk in the pharmacy waiting
area; 2) DACH Dining facility; 3) Medical library; 4) Plans,
Operations, and Mobilization, Bldg 815; 5) Community Mental
Health Service reception desk, Bldg 1030. You may also return
your survey directly to the point of contact in paragraph 7.

7. You may direct any questions regarding the survey to Major
Michael P. Goodwin, DeWitt Army Community Hospital, Room A117,
805-0881.

ORGANIZATIONAL CULTURE QUESTIONNAIRE

Use the following scale to indicate your response to the
statements presented below.

strongly disagree	disagree	neutral	agree	strongly agree
A	B	C	D	E

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1. People in the organization are aware of its overall mission.

2. People in the organization are aware of how their jobs contribute to the organization's mission.

3. It's in everyone's best interest that the organization be successful.

4. People in the organization try to plan ahead for changes (such as customer expectations) that might impact the organization's future performance.

5. People in the organization try to plan ahead for technological changes (such as new developments in computer software) that might impact on the organization's future performance.

6. People in the organization regularly work together to plan for the future.

7. Creativity is actively encouraged in the organization.

8. Innovators are the people who get ahead in the organization.

9. The quality of work produced is the primary focus of the organization.

10. People in the organization see the continuing improvement of work produced as essential to the success of the organization.

11. The organization emphasizes doing things right the first time.

strongly disagree	disagree	neutral	agree	strongly agree
A	B	C	D	E

12. People in the organization live up to high ethical standards.

13. People in the organization like to do a good job.

14. People in the organization help each other get the job done.

15. Leader(s) in the organization ask people about ways to improve the work produced.

16. Leader(s) in the organization encourage people to voice their concerns.

17. Leader(s) in the organization follow up on suggestions for improvement.

18. Leader(s) in the organization set examples of quality performance in their day-to-day activities.

19. Leader(s) in the organization regularly review the organization's progress toward meeting it's goals and objectives.

20. Leader(s) in the organization attempt to find out why the organization may not be meeting a particular goal.

21. People in the work unit turn to their supervisors for advice about how to improve their work.

22. People in the work unit know that their supervisors will help them find answers to problems they may be having.

23. People in the work unit are challenged by their supervisors to find ways to improve the system.

strongly disagree	disagree	neutral	agree	strongly agree
A	B	C	D	E

---

24. Supervisors in the work unit make the continuous improvement of the work produced top priority.

25. Supervisors in the work unit regularly ask the customers about the quality of the work they receive.

26. Supervisors in the work unit ask people for the ideas and opinions about their work.

27. The structure of the organization makes it easy to focus on producing quality work.

28. People know how the work produced in their work unit fits in with the work produced by other work units.

29. People in the work unit can describe the organization's quality and/or productivity policy.

30. People in the work unit know how to define the quality of work they produce.

31. People in the work unit take pride in their work.

32. People in the work unit share responsibility for the success or failure of the work produced.

33. People in the work unit believe their work is important to the success of the organization.

34. There are good working relationships between units in the organization.

35. A spirit of teamwork and cooperation exists in the organization.

strongly disagree	disagree	neutral	agree	strongly agree
A	B	C	D	E

36. The organization has good working relationships with other organizations.

37. People in the work area look for ways to improve their work.

38. People in the work unit discuss ways to improved the work produced.

39. The work unit has appropriate personnel to get the job done properly.

40. Work expectations for the work unit are fair.

41. People in the work unit are expected to produce high quality work.

42. People in the work unit are friendly with one another.

43. People in the work unit enjoy their co-workers.

44. The right tool, equipment, and materials are available in the work unit to get the job done.

45. The distribution of work among the people in the work unit is well balanced.

46. There is ample time for people in the work unit to perform jobs in a professional manner.

47. The pay scale is fair for people in the work unit.

48. Attempts are made to promote the people in the work unit who do good work.

strongly disagree	disagree	neutral	agree	strongly agree
A	B	C	D	E

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49. People in the work unit receive promotions because they earn them.

50. There is quick recognition for people in the work unit for outstanding performance.

51. The organization rewards the people in the work unit for working together.

52. People in the organization know who their customers are.

53. People in the organization care about their customers.

54. In general, customers know that the organization cares about what they think.

55. The organization's customers are asked for their opinions about the work (care, services, or product) they received for the organization.

56. Effective communication channels exists between work units in the organization.

57. People in the work unit do not have to rely on "the grapevine" or rumors for information.

58. The facts and information needed to do a good job are available to people in the work unit.

This completes the opinion portion of the survey. To assist in the analysis of the survey, please mark number 59 in the appropriate block:

    If you are a military member, mark "A"
    If you are a civilian, mark "B"

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